City of Duluth

2010 Open Enrollment Guide

For Plan Year:
January 1 - December 31, 2010

Deadline for submitting forms:
Friday, December 4, 2009

Annual Open Enrollment Period: November 23 - December 4, 2009

- Open Enrollment is your opportunity to change your health and/or dental benefits election for the upcoming calendar year.
- If you wish to participate in the medical and/or dependent daycare Flexible Spending Account (FSA) plan, you must enroll <u>every</u> year.
- If you do not wish to make changes to your current health and/or dental coverage, you do not have to complete the Employee Data Maintenance Form (EDMF).
- If you provide health and/or dental coverage to a dependent child, age 19 through 24 anytime during the 2010 plan year, you must complete and submit a Certification of Dependent Status form along with the appropriate required documentation.
- If you have family health care coverage for your spouse and/or dependent children, please read through the Medicare Secondary Payer (MSP) Mandatory Reporting Requirements on Page 7 of this Guide. As the "responsible reporting entity" (RRE), the City of Duluth will be required to report information on all covered individuals on the health plan to the Centers for Medicare & Medicaid Services (CMS)

Two Easy Steps for a Successful Open Enrollment:

1. Gather Information

- ***<u>Carefully review the information in this Guide and in your enrollment packet:</u>***
  - Available benefit plan selections
  - 2010 monthly health, dental, and life insurance premiums
  - Instructions regarding required documentation for dependent children, ages 19 through 24, covered under your health and/or dental plans
  - Benefits Statement outlining your current benefit elections (this may be of use to you as you review the enclosed Open Enrollment material)
- ***<u>Open Enrollment Meetings</u>***
  - For your convenience, Human Resources staff will be available to assist with Open Enrollment questions (see Page 15 for details)

2. Enroll

- ***If you are not making any changes to your current health and dental elections, you do not need to complete the EDMF.*** However, if you continue to provide health and/or dental coverage to a dependent child, age 19 through 24 anytime during the 2010 plan year, you must complete and submit a Certification of Dependent Status form along with the appropriate required documentation.
- **If you are making a change to your current health and/or dental elections, you must complete the EDMF and submit it to the Human Resources Office no later than 4:30 p.m. on Friday, December 4, 2009.** If you provide health and/or dental coverage to a dependent child, age 19 through 24 anytime during the 2010 plan year, you must complete and submit a Certification of Dependent Status form along with the appropriate required documentation.
- ***If you wish to participate in the medical and/or dependent day care FSA plan in 2010, you must complete the SuperiorUSA Election/Change Form and submit it to the Human Resources Office no later than 4:30 p.m. on Friday, December 4, 2009.*** Remember, employees with Single health plan coverage receive a $75/month contribution that may be designated towards the FSA plan and/or a Deferred Compensation plan.
- *At any time during the year, if you are interested in applying for additional term life insurance coverage for yourself, your spouse, or your eligible child(ren),* please complete and submit the appropriate insurance application form. Upon notice of approval from Minnesota Life, the City of Duluth will begin deducting premiums from employee paychecks.

2010 Health Plan Premiums[*]
City of Duluth - Plan 3

2010 Single Health Plan Premiums for Basic, Confidential, Fire, Police, & Supervisory Units		
	Monthly	**Per Paycheck**[‡]
Total Single Premium	**$ 475.08**	**$ 237.54**
City Contribution	$ 475.08	$ 237.54
Employee Contribution	*$ -*	*$ -*

2010 Family Health Plan Premiums for Basic, Fire, Police, & Supervisory Units		
	Monthly	**Per Paycheck**[‡]
Total Family Premium	**$1,170.21**	**$ 585.11**
City Contribution	$ 936.17	$ 468.09
Employee Contribution not using Employer Deferred Compensation Plan Contribution[**]	*$ 234.04*	*$ 117.02*
OR		
Employee Contribution using Employer Deferred Compensation Plan Contribution[**]	*$ 5.04*	*$ 2.52*
[**]**Employer Deferred Compensation Plan Contribution** May be applied toward either your Family Health Plan Premium OR a Deferred Compensation plan. This election may only be changed during the Open Enrollment period or in the event of a qualifying family status change.	**Monthly** $ 229.00	**Per Paycheck**[‡] $ 114.50

2010 Family Health Plan Premiums for Confidential Unit Only		
	Monthly	**Per Paycheck**[‡]
Total Family Premium	**$1,170.21**	**$ 585.11**
City Contribution	$ 936.17	$ 468.09
Employee Contribution not using Employer Deferred Compensation Plan Contribution[**]	*$ 234.04*	*$ 117.02*
OR		
Employee Contribution using Employer Deferred Compensation Plan Contribution[**]	*$ (10.96)*[✦]	*$ (5.48)*[✦]
[**] **Employer Deferred Compensation Plan Contribution – Confidential Unit** May be applied toward either your Family Health Plan Premium OR a Deferred Compensation plan. This election may only be changed during the Open Enrollment period or in the event of a qualifying family status change.	**Monthly** $ 245.00	**Per Paycheck**[‡] $ 122.50
✦ If opting to apply Employer Deferred Compensation Plan Contribution to Family Health Plan Premiums, Confidential Unit members must assign the remaining $5.48 per paycheck to a Deferred Compensation plan or the money will be forfeited.		

[*] The premiums outlined above apply to full-time employees. Part-time employees should contact the Human Resources Office at (218) 730-5210 for further information.

[‡] Per Paycheck amounts are calculated using only 24 pay periods; for months that contain a third pay period end date (January and August in 2010), no premium deduction will be withheld from the employee's paycheck.

Hospital and Medical Health
Plan 3 Summary**
January 1 – December 31, 2010

Benefit Features, Limitations, and Maximums		
Deductible	**Individual**	$250
	Family	$500
Out-of-Pocket Maximum**	**Individual**	$1,250
	Family	$2,500
Coinsurance		80% after deductible to Out-of-Pocket Maximum
Lifetime Maximum		$2 million

COVERED SERVICES

Preventive Care		
The Plan Covers:	**In-Network Providers**	**Out-of-Network Providers****
• Routine physical exam* • Routine cancer screening* • Routine hearing exam* • Lab and x-ray services • Immunizations • Routine vision exam* • Well-child care (up to age 6)	100%	100%
	*One routine physical, cancer screening, vision, and hearing exam per calendar year	
Hospital Services		
Hospital Inpatient	**In-Network Providers**	**Out-of-Network Providers****
• Facility services • Professional services	80% after deductible	80% after deductible
Hospital Outpatient	**In-Network Providers**	**Out-of-Network Providers****
• Facility services • Professional services • Lab and x-ray services	80% after deductible	80% after deductible
Physician Services		
The Plan Covers:	**In-Network Providers**	**Out-of-Network Providers****
• Office visits for illness • Urgent care • Allergy-related services • Surgery • Lab and x-ray services	80% after deductible	80% after deductible
Emergency Services		
Emergency Room Care	**In-Network Providers**	**Out-of-Network Providers****
• Emergency room • Physician services	80% after deductible	80% after deductible
Ambulance Services	80% after deductible	80% after deductible

Hospital and Medical Health
Plan 3 Summary⁂
January 1 – December 31, 2010

Maternity Care		
The Plan Covers:	**In-Network Providers**	**Out-of-Network Providers⁂**
• Prenatal Care	100%	100%
• Facility services for delivery • Professional services for delivery	80% after deductible	80% after deductible
Durable Medical Equipment and Supplies		
The Plan Covers:	**In-Network Providers**	**Out-of-Network Providers⁂**
• Durable medical equipment • Medical Supplies	80% after deductible	80% after deductible
Behavioral Health (Mental Health and Chemical Dependency)		
The Plan Covers:	**In-Network Providers**	**Out-of-Network Providers⁂**
• Physician Services • Inpatient Services • Outpatient Services	80% after deductible	80% after deductible
Rehabilitative Care		
The Plan Covers:	**In-Network Providers**	**Out-of-Network Providers⁂**
• Physical therapy • Occupational therapy • Speech therapy	80% after deductible	80% after deductible
Chiropractic Care		
The Plan Covers:	**In-Network Providers**	**Out-of-Network Providers⁂**
• Chiropractic Care	80% after deductible	80% after deductible

Prescription Drug Benefits through ClearScript		
Tier		**Co-Pay Amount**
First:	Generic Drugs	$0
Second:	Preferred Brand Name medications	$15
Third:	Non-Preferred Brand Name medications	30% coinsurance ($30 min/$100 max)
Medication Therapy Management (MTM) program available		

⁂ **When using out-of-network providers, you may be responsible for filing your own claims and for any charges that exceed the Blue Cross and Blue Shield (BCBS) allowed amount. These amounts are not applied to the out-of-pocket maximum.**

Please read the information on the following page to verify network provider status.

This is a general outline of plan benefits. The contract and summary plan description include complete details of what is and isn't covered and governs if there are any discrepancies in the general outline of benefits.

Important Reminder when choosing a Health Care Provider

Members enrolled in the City of Duluth's health plan may choose any eligible provider of health services for the care that is needed. The plan may pay higher benefits when an in-network provider is chosen.

In-Network Providers

When you choose an in-network provider, you receive the maximum benefit allowable under the plan provisions. These providers send your claims directly to Blue Cross and Blue Shield of Minnesota (BCBSMN) for services you receive.

To locate an in-network provider near you, you may:

1.) Contact your provider or facility directly to determine in-network status;

2.) Contact the BCBSMN Customer Service Dept. at 1-800-382-2000 (TDD 1-888-878-0137); or

3.) Visit the online* member service center at www.bluecrossmn.com, under "Resources" select "Find A Doctor" and choose the "Blue Cross Aware" network.

* Please be aware that the online provider directory may be subject to change as providers enroll or terminate their agreements. It is your responsibility to confirm whether your provider is participating in the network at the time you receive medical services.

Out-of-Network Providers

Members choosing to utilize out-of-network providers or facilities may incur additional out-of-pocket expenses and are responsible for any charges that exceed the allowed amount. Additionally, out-of-network providers/facilities may not take care of notification requirements or file claims on your behalf.

Please refer to the online health plan summary document for a description of charges that are your responsibility:

http://www.duluthmn.gov/employment/Benefits/2008%20COD%20Plan%203A.pdf

Medicare Mandatory Reporting Requirements

SUMMARY

The Medicare Secondary Payer (MSP) Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Extension Act requires that you provide a Social Security Number for yourself and your covered dependent(s) to your group health plan. Due to this regulation, you will be required to provide your dependents' Social Security Numbers to complete enrollment in the group health plans.

This new federal law requires carriers to engage in a Medicare Secondary Payer (MSP) data exchange in order for the Centers for Medicare and Medicaid Services (CMS), to identify more members where group coverage is primary and Medicare coverage is secondary.

Effective January 1, 2009, all employers, insurers and plan administrators must share member eligibility data with CMS. The increased exchange of eligibility data will ultimately reduce coordination of benefits errors, allow for a more efficient process and help avoid unnecessary interest payments.

BACKGROUND

Since 2002, Blue Cross and Blue Shield of Minnesota and other health plans have been providing information about our members who have group coverage as the primary payer and Medicare as the secondary payer via a Voluntary Data Exchange Agreement (VDEA). The MSP statute makes the previously voluntary eligibility data-sharing program into a mandatory requirement for all employers, insurers and plan administrators.

WHAT THIS MEANS

As part of the MSP statute's eligibility data sharing mandate, CMS has required that carriers provide active (as of 01/01/09) member Social Security Numbers (SSNs) within the following time frames:

- Social Security Numbers for current subscribers, including new subscribers and dependents with a 01/01/09 effective date (or post 01/01/09 effective date), are required by CMS as of January 1, 2010, and therefore need to be submitted to the City of Duluth's Human Resources Office ***as soon as possible.***
- Social Security Numbers for dependents who were on file prior to 12/31/08 are required by CMS as of January 1, 2011, however, should be submitted to the City of Duluth's Human Resources Office ***as soon as possible.***

You may contact the Blue Cross and Blue Shield of Minnesota Customer Service Center at 1-800-531-6676 to determine if your dependent's Social Security Number is on file.

Per the MSP statute, failure to report eligibility data and Social Security Numbers as outlined above may subject the required reporting entity – insurers, third party administrators, employers and/or plan administrators – to civil monetary penalties up to $1,000 for each day of noncompliance for each individual for which data exchange is required.

FOR MORE INFORMATION

For more information on the Medicare Secondary Payer program Statutory Language Section 111, P.L. 110-173, please visit http://www.cms.hhs.gov/MEDICARESECONDPAYERANDYOU/.

Plan Eligibility

Eligible Employees

All regular and provisional employees working a minimum of 14 hours per week are eligible.

Eligible Dependents

Spouse

Spouse, meaning:

a.) Legally married opposite gender spouse; or
b.) Legally separated opposite gender spouse.

Dependent Children*

a.) Unmarried natural-born dependent children through age 24
b.) Unmarried legally adopted children and children placed with you for legal adoption through age 24. Date of placement means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
c.) Unmarried stepchildren through age 24 who live with you.
d.) Unmarried legal wards through age 24 who are claimed as exemptions on your Federal income tax return and financially dependent upon you.
e.) Unmarried grandchildren through age 24 who are claimed as exemptions on your Federal income tax return and financially dependent upon you.
f.) Unmarried children of the employee who is required to be covered by reason of a Qualified Medical Child Support Order (QMCSO).

***Covering Dependent Children Ages 19 through 24**

Under the terms of the City of Duluth's medical and dental plans, you may cover your unmarried children aged 19 through 24 even if they are not full-time students. **However, this coverage may have tax implications for you.**

Tax Implications

You must pay taxes on the value of health/dental coverage provided to an unmarried child aged 19 through 24 who does not meet the Internal Revenue Code definition of a "qualifying child". The tax value of medical coverage is equal to the single medical premium rate; for 2010, the single medical premium is $475.08 per month or $5,700.96 per year. The tax value of dental coverage is equal to the single equivalence rate for the dental plan option elected; the Single Low Option dental premium is $32 per month or $384 per year ($52/month or $624/year for Confidential Unit members) and the Single High Option dental premium is $73 per month or $876 per year.

Important note: You may only receive reimbursement from the FSA plan for expenses incurred by yourself and by individuals who are considered "dependents" under the Internal Revenue Code.

Additional information can be found in the enclosed Certification of Dependent Status policy.

About the MTM Program Offered by the City of Duluth

Eligibility

Medication Therapy Management (MTM) is available to members covered under the City of Duluth's Hospital Medical Benefit Plan who:

- use four or more program-specified maintenance medications; OR
- have diabetes; OR
- are diagnosed with at least two of the following chronic conditions: high blood pressure, high cholesterol, asthma, chronic pulmonary disease, heart failure, or depression.

Program Goals

The goal of this program is to improve your health and help you avoid costly medical care. A pharmacist will work with you and your other health care providers to help you manage your medications better and reduce your risk of complications. The pharmacist can also advise you how to eat healthier, exercise more, and stop smoking. **If you are interested in finding out more about the MTM program, please call 1-866-332-3708**.

Participation

To participate, you must choose a participating pharmacy where you would like to go for your medication therapy management visits (you may continue to get your prescriptions filled at any of the 61,000 pharmacies in your benefit plan network). Someone will call you to schedule your first appointment. You will then meet privately with a pharmacist at least every three months or as directed by your pharmacist. You will not be charged for these appointments. During the appointments, the pharmacist will talk with you about:

- Your medicine - how you are taking it, how well it is working, and any side-effects you may be having
- Your treatment goals and your action plan to meet those goals
- Healthy eating
- Exercising

At your first appointment, the pharmacist will ask you what you know about your medical conditions and how they are being treated. Then the pharmacist will develop an action plan just for you.

Cost Savings

Not only will you learn how to manage your health conditions better, but you will also save money by getting selected medicines at a reduced co-payment(s).

2010 Dental Plan Premiums[*]

Employees may select either Low or High Option. Selection may be changed each year only during Open Enrollment or during the year within 30 days of a "Life Qualifying Event". When an employee elects to take Family or Single + One dental coverage, the employee shall maintain such coverage for not less than two (2) consecutive years.

Basic, Fire, Police, & Supervisory Units – $1,000 Annual Benefit (Low Option)
2010 Dental Plan Monthly Premium

Plan	Premium	City Contribution	**Employee Cost**	COBRA Cost
Single	$ 32.00	$ 32.00	**$ 0.00**	$ 32.64
Single + One	$ 65.00	$ 32.00	**$ 33.00**	$ 66.30
Family	$ 106.00	$ 32.00	**$ 74.00**	$ 108.12

Basic, Fire, Police, & Supervisory Units – $2,000 Annual Benefit (High Option)
2010 Dental Plan Monthly Premium

Plan	Premium	City Contribution	**Employee Cost**	COBRA Cost
Single	$ 73.00	$ 32.00	**$ 41.00**	$ 74.46
Single + One	$ 122.00	$ 32.00	**$ 90.00**	$ 124.44
Family	$ 219.00	$ 32.00	**$ 187.00**	$ 223.38

Confidential Unit – $1,500 Annual Benefit (Low Option)
2010 Dental Plan Monthly Premium

Plan	Premium	City Contribution	**Employee Cost**	COBRA Cost
Single	$ 52.00	$ 52.00	**$ 0.00**	$ 53.04
Single + One	$ 105.00	$ 52.00	**$ 53.00**	$ 107.10
Family	$ 156.00	$ 52.00	**$ 104.00**	$ 159.12

Confidential Unit – $2,000 Annual Benefit (High Option)
2010 Dental Plan Monthly Premium

Plan	Premium	City Contribution	**Employee Cost**	COBRA Cost
Single	$ 73.00	$ 52.00	**$ 21.00**	$ 74.46
Single + One	$ 122.00	$ 52.00	**$ 70.00**	$ 124.44
Family	$ 219.00	$ 52.00	**$ 167.00**	$ 223.38

[*] The premiums for family coverage outlined above apply to full-time employees. Part-time employee premiums can be obtained by calling the Human Resources Office at (218) 730-5210.

City of Duluth Active Employee Dental Plan Summary of Benefits
Administered through Delta Dental Plan of Minnesota
January 1, 2010

You may choose any eligible provider of dental services for the care you need. The Plan may pay higher benefits if you choose a Delta Dental participating provider.

Additional Dental Plan Network Savings!
The maximum fee allowed by the Delta Dental PPO is lower than the maximum fee allowed by Delta Premier or by out-of-network providers. No matter which dental plan option you enroll in, in addition to the Delta Premier network, you now have the Delta Dental PPO network to choose from and receive deeper network savings!

Delta Dental PPO and Delta Premier Providers (In-Network):
When you choose a Delta Dental PPO network provider, you receive the highest level of benefits. If you choose a Delta Premier network provider, you still receive a higher level of benefits over an out-of-network provider. Both Delta Dental PPO and Delta Premier providers will send your claims directly to Delta Dental. For a list of participating providers, call Delta Dental at 1-800-553-9536 or visit their website at www.deltadental.org.

Out-of-Network Providers:
If you decide to utilize an out-of-network provider, you may incur more out-of-pocket expense. Members are responsible for paying any amount charged by out-of-network providers in excess of the "Allowed Amount" that the in-network provider has agreed to accept as full payment for a covered service at the time your claim is processed. Additionally, you are responsible for submitting your own claim and reimbursing your provider directly.

Service & Description	Delta Dental PPO & Delta Premier	Out-of-Network Providers
Diagnostic & Preventive Services (Exams and cleanings, x-rays, fluoride treatments, space maintainers)	100%	100%
Basic Services (Emergency treatment for relief of pain, sealants, amalgam restorations (silver fillings) and composite resin restorations (white fillings) on anterior (front) teeth)	80%	80%
Endodontics (Pulpotomies on primary teeth for dependent children, root canal therapy on permanent teeth)	80%	80%
Periodontics (Surgical/Nonsurgical periodontics)	80%	80%
Oral Surgery (Surgical/nonsurgical extractions, all other oral surgery)	80%	80%
Major Restorative (Crowns and composite resin restorations (white fillings) on posterior (back) teeth)	80%	80%
Prosthetic Repairs and Adjustments (Denture adjustments and repairs, bridge repair)	50%	50%
Prosthetics (Dentures – full and partial, bridges)	50%	50%
Deductible	NONE	NONE
Calendar Year Benefit Plan Maximum Low Option - *Basic, Fire, Police, & Supervisory Units*	$1,000	$1,000
Calendar Year Benefit Plan Maximum Low Option - *Confidential Unit Only*	$1,500	$1,500
Calendar Year Benefit Plan Maximum High Option - *Basic, Confidential, Fire, Police & Supervisory*	$2,000	$2,000

This is a benefit summary only and does not outline all of your benefits. If there is a discrepancy between information in this summary and the Plan Document, the Plan Document will take precedence in determining your benefits.

Why Flexible Spending Accounts are a Plus

The Open Enrollment period is the time to enroll or re-enroll in Flexible Spending Accounts (FSA). Those who expect to have between $130 (minimum $5 per paycheck) and $5,000 (maximum $192.30 per paycheck) of out-of-pocket expenses in 2010 should consider enrolling in a FSA plan.

Advantages of a Health FSA:

- **A planned approach to paying out-of-pocket health/dental expenses** – You set aside money that you will have to pay anyway in a pre-tax account from which you can draw to pay eligible health/dental care expenses for yourself, your spouse and those whom you claim as federal tax dependents.
- **Affordable pre-tax contributions** – You contribute an equal portion of the total annual amount of your account by pre-tax deductions each pay period (26 pay periods).
- **Total account access** – The total annual amount you elected is available immediately.
- **Tax savings** – Because your deductions are taken before taxes, your tax liability is reduced.
- **Examples of qualifying out-of-pocket medical expenses:**
  - Deductibles
  - Hearing aids & batteries
  - Diabetic supplies
  - Co-pays & Coinsurance
  - Dental out-of-pocket expenses
  - Eyeglasses, contact lenses
  - Corrective vision surgery
  - Over-the-counter drugs used to alleviate/treat personal injuries/sickness

Advantages of a Dependent Daycare FSA:

- **A planned approach to paying dependent daycare expenses** – You set aside money that you will have to pay anyway in a pre-tax account from which you can draw to pay eligible dependent daycare expenses for your children or dependent adult family members.
- **Affordable pre-tax contributions** – You contribute an equal portion of the total annual amount of your account by pre-tax deductions each pay period (26 pay periods).
- **Tax savings** – Because your deductions are taken before taxes, your tax liability is reduced.
- **Examples of qualifying dependent daycare expenses[*]:**
  - Childcare for dependents under the age of 13 that is necessary in order for you and your spouse to work or attend school full-time
  - Before & after-school care
  - Custodial care for qualified tax dependents
  - Elder care, including adult daycare

[*]In divorce situations, only the custodial parent can claim childcare expenses

Some important factors to consider before making your decision:

- Go to the SuperiorUSA website, www.superiorusa.com for more details about the FSAs. You will find a list eligible expenses that qualify for reimbursement, and FSA calculators to help you estimate the amount you should contribute and your tax savings.
- You may enroll in the plan only during the Open Enrollment period or when you first become eligible.
- Qualified expenses must be incurred during your period of coverage. Expenses are considered incurred on the date the service is provided, regardless of when it is billed, charged, or paid for.
- If by chance you do not use up all of your funds by the end of the plan year, your funds will be forfeited.
- **You may only receive reimbursement from the FSA plan for expenses incurred by yourself and by individuals who are considered "dependents" under the Internal Revenue Code.**

Employee Assistance Program

The City of Duluth understands that everyone has difficulties in their lives. Sometimes these obstacles can keep us from feeling our best and doing our best at work and at home. We would like to remind you that the City of Duluth has an Employee Assistance Program (EAP). As an eligible employee, this confidential service is available to you and your immediate household members, even if they are not covered under the City's health plan.

EAP can help you with:

- Marriage & Relationships
- Mental Health
- Stress
- Substance Abuse
- Work-related Issues
- Grief
- Children & Elder Care
- Family Problems
- Financial Matters
- Legal Referrals

An EAP counselor is available 24/7 and can help you work through challenging personal problems and guide you to available resources. Together you can develop an action plan to help resolve your problem. EAP services are confidential and provided at no additional charge. If your counselor refers you to resources outside of EAP, there may be costs for which you or your health plan is responsible.

If you are dealing with an obstacle or a challenging life event, calling EAP can be your first step in a new direction. If you have questions about the services or if you need to talk with an EAP Counselor, call 1-800-383-1908.

Additionally, online services are available at www.midwesteap.com

username: cityofduluth
password: member

Contact Information	Phone No.	Websites
Blue Cross and Blue Shield of Minnesota* Customer service representatives are available to answer general and individual specific questions regarding: - health plan benefits (e.g., general information regarding plan deductible, coinsurance, annual out-of-pocket maximums, lifetime maximums, allowable services, general exclusions, etc.) - claims (e.g., for an explanation of deductibles or out-of-pocket expenses incurred, claims filing or payment, etc.) - benefit coordination (e.g., Medicare or other group insurance, subrogation, etc.) - network providers (e.g., identifying in-network vs. out-of-network providers/clinics/hospitals or chiropractors)	1-800-531-6676 (651) 662-5001	www.bluecrossmn.com
ClearScript* Customer service representatives are available to answer general and individual specific questions regarding: - prescription drug plan benefits (e.g., general information regarding plan co-payments and/or coinsurance, preferred drug list, specialty drugs, Medication Therapy Management program (MTM), general exclusions, etc.) - claims (e.g., for an explanation of charges, claims filing or payment, etc.), - benefit coordination (e.g., other group insurance) - network providers (e.g., participating pharmacies)	ClearScript Customer Service 1-800-546-5677 MTM Phone # 1-866-332-3708.	www.clearscript.org
Delta Dental Plan of Minnesota* Customer service representatives are available to answer general and individual specific questions regarding: - dental plan benefits (e.g., general information regarding coinsurance, annual benefit amounts, allowable services, general exclusions, etc.) - claims (e.g., for an explanation of out-of-pocket expenses incurred, claims filing or payment, etc.) - benefit coordination (e.g., other group insurance) - network providers (e.g., identifying in-network vs. out-of-network providers)	1-800-553-9536 (651) 406-5916	www.deltadentalmn.org
SuperiorUSA – Flexible Spending Account Plans Customer service representatives are available to answer questions regarding the medical and dependent daycare reimbursement account plans	1-877-529-2477 (218) 529-2477	www.superiorusa.com
Employee Assistance Program Confidential services available to employees and their family members.	1-800-383-1908	www.midwesteap.com username: cityofduluth password: member

*Please have your group and member identification numbers available to facilitate discussions with the customer service representative.

How can I get more information about Open Enrollment?

Open Enrollment Meetings
Human Resources staff will be available to assist you with Open Enrollment questions on the following dates:

Date	Time	Locations
Monday, November 30th	11:30 a.m. – 1:30 p.m.	City Council Chambers
Tuesday, December 1st	11:30 a.m. – 1:30 p.m.	40th Ave. West Tool House
Wednesday, December 2nd	9:00 a.m. – 11:00 a.m.	Garfield Lunch Room
Wednesday, December 2nd	2:00 p.m. – 4:00 p.m.	Garfield Lunch Room

Contact a Human Resources Representative
Staff in the Human Resources Office is trained to answer your questions and help you with Open Enrollment procedures.

- Human Resources Front Desk (218) 730-5210
- Marlene Van Puymbrouck (218) 730-5198
- Tammie Walsh (218) 730-5199

City of Duluth Website, Human Resources Home Page
A variety of information is available at the City of Duluth Human Resources home page, under *Employee Benefits*, http://www.duluthmn.gov/employment/.

Important Open Enrollment Notes

Membership ID Cards
If you are enrolling new dependents to your health and/or dental plan, or if you are making a change to your dental plan option, new Membership ID Card(s) will be issued by mid-January. If you have not received your new Membership ID Card(s) by January 16, 2010, please contact our carriers:

- Blue Cross and Blue Shield of Minnesota 1-800-531-6676
- ClearScript 1-800-546-5677
- Delta Dental 1-800-553-9536

Payroll Deductions
For employees electing coverage other than Single health or Single Low Option dental, the first deduction for the employee portion of the benefit premium(s), including the FSA plan, begins as follows:

- Health plan premium deductions, first paycheck in January 2010
- Dental plan premium deductions, second paycheck in January 2010
- FSA plan deductions, first paycheck in January 2010

The first deduction for term life insurance coverage requiring evidence of good health will be taken immediately after notification of coverage approval by the carrier. The benefit coverage will take effect the day it is approved.

Important Notice from the City of Duluth about your Prescription Drug Coverage and Medicare

Please read this notice carefully. This notice has information about your current prescription drug coverage in the City of Duluth's health plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1.) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2.) The City of Duluth has determined that the prescription drug coverage offered through its medical and prescription drug plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare Drug Plan?
You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug Plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan?
If you decide to join a Medicare Drug Plan, your current City of Duluth health coverage will not be affected. If you decide to join a Medicare Drug Plan and drop your City of Duluth health coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the City of Duluth's health plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare Drug Plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go to nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this Notice or your current prescription drug coverage…

Contact Marlene Van Puymbrouck at (218) 730-5198 or Tammie Walsh at (218) 730-5199.

For more information about your options under Medicare Prescription Drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook (http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf). If you are Medicare eligible, you will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare Drug Plans.

For more information about Medicare Prescription Drug coverage…

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (refer to the inside back cover of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Please keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	November 4, 2009
Name of Entity/Sender:	City of Duluth
Contact – Position/Office:	Human Resources, Benefits
Address:	411 W. First Street, 313 City Hall, Duluth, MN, 55802
Phone Number:	(218) 730-5198 or (218) 730-5199

Women's Health and Cancer Rights Act of 1998 Annual Notice

Did you know that your benefit plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy including lymphedema? Services and supplies will be in a manner determined in consultation with the attending physician and patient. Such coverage may be subject to annual deductibles, coinsurance, and other plan provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

If you have any questions concerning your coverage, including pre-certification requirements, please contact the Blue Cross and Blue Shield of Minnesota Customer Service Center at 1-800-531-6676.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending health professional (such as your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care professional obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain physicians or facilities or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Blue Cross and Blue Shield of Minnesota Customer Service Center at 1-800-531-6676.

The Federal Mental Health Parity Act

The Federal Mental Health Parity Act was signed into law on Oct. 3, 2008 (the "2008 Act"), as part of the recently enacted economic recovery package (Sections 511 and 512 of HR 1424, PL 110-343). The new law, which amends ERISA, the Internal Revenue Code and the Public Health Service Act, requires insured and self-insured plans to provide "parity" between the financial requirements and treatment limitations applied to: (a.) mental health and substance use disorder benefits; and (b.) medical and/or surgical benefits.
This requirement will take effect for most plans on the first day of their plan year which begins or renews on or after Oct. 3, 2009.

NEW REQUIREMENTS

- The new law does not allow either more restrictive or separate financial requirements for mental health and substance use disorder coverage. It specifically defines the 'financial requirements' that must be in parity as:
  1.) Deductibles
  2.) Co-payments
  3.) Coinsurance
  4.) Out-of-pocket expenses

- However, a plan may still have an aggregate lifetime limit and an aggregate annual limit that is applied to both medical and mental health and substance use disorder benefits.

- The law prohibits treatment limits on mental health and substance use disorder benefits that are more restrictive than those of medical/surgical benefits. The law specifically requires the following limitations to be in parity:
  1.) Limits on frequency of treatment
  2.) Limits on number of visits
  3.) Limits on number of days of coverage
  4.) Other similar limits on the scope or duration of coverage

- The law requires an explanation of a denial of benefits for mental health and substance use disorder treatment (if requested)

- The law also requires out-of-network (OON) coverage for mental health and substance use disorder treatment if OON coverage is available for medical/surgical benefits

- Employers who have behavioral health benefit limits or cost-sharing requirements will need to review those restrictions against their medical benefits coverage in order to assess whether they meet federal parity requirements of the 2008 Act and, if not, to determine what adjustments need to be made to your plan design to achieve compliance. This review will need to be completed well in advance of the effective date stated above.

- Under the new law, employers can choose which mental health and substance use diagnoses they want to cover. The parity requirements will apply to all diagnoses the employer chooses to cover (subject to applicable state law mandates; many states currently have limits on specific diagnoses such as autism, for example). An employer can not choose to cover some diagnoses at parity and others not at parity.

COMPLAINTS AND QUESTIONS

If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City's Human Resources Office or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.